

Altered Mental Status and Delirium



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KEYWORDS

- Delirium • Dementia • Elderly • Emergency medicine • Altered mental status
- Medical decision-making capacity

KEY POINTS

- Altered mental status or change in behavior in an older patient presenting to the emergency department frequently represents delirium.
- Diagnosing delirium occurs at the bedside by the emergency physician and includes objective screening measures for level of consciousness and cognition followed by confirmatory testing.
- Delirium is often caused by a potentially life-threatening underlying condition and carries a poor prognosis if unrecognized.
- Determining the cause of delirium takes a thorough evaluation, including interviewing any available surrogates, reviewing medications, considering a broad differential, including infection, trauma, stroke, and performing comprehensive diagnostic testing.
- Treatment of delirium includes treating the underlying cause as well as careful administration of antipsychotic drugs when nonpharmacologic treatments are insufficient.

INTRODUCTION

Older patients who present to the emergency department (ED) frequently have acute or chronic alterations of their mental status, including their level of consciousness and cognition. Recognizing both acute and chronic changes in cognition are important for emergency physicians. Chronic changes in cognition due to dementia may affect the reliability of patients' histories as well as their ability to follow discharge instructions.¹ Failure to recognize this chronic impairment may therefore affect patient outcomes.

Most importantly for emergency physicians is to recognize acute changes in mental status. When older patients present with change in mental status as a chief complaint, it is nearly always caused by delirium.² Delirium is characterized by an acute (hours to days) fluctuating change in attention, awareness, and cognition as defined by the

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Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.³ Older ED patients with delirium have an increased risk of mortality compared with nondelirious patients. The failure of ED physicians to diagnose delirium may also increase a patient's mortality, as mortalities are more than twice as high in patients in whom delirium was not diagnosed in the ED, compared with those in whom delirium was diagnosed and nondelirious patients.⁴ Crucial to avoiding missed delirium is understanding the subtypes of delirium, which include hyperactive, mixed, and hypoactive states, with the most common being hypoactive.⁵ Hypoactive delirium can be misinterpreted as "fatigue" or "not acting like themselves" by caregivers, making this subtype of delirium most challenging to recognize.

Consequently, it is the task of the emergency physician to recognize both acute and chronic mental status changes. A structured approach to the rapid assessment of cognitive status is required. Emergency physicians must have a high index of suspicion for delirium, and once suspected, conduct a thorough evaluation to find the underlying cause.

Evaluation of Altered Mental Status and Delirium

Delirium risk assessment

The emergency physician needs to gather predisposing risk factors for the development of delirium while taking the history of an elderly patient (**Table 1**).⁶ Predisposing risk factors lower the threshold for a patient to become delirious when faced with a precipitating cause (**Fig. 1**). Furthermore, some predisposing risk factors can themselves cause delirium.

It is essential to include a review of the patient's active medication list for polypharmacy and for drugs that are known to cause confusion listed on the updated Beers criteria.^{7,8} Notorious drug classes to screen for are anticholinergics, benzodiazepines, opiates, antidepressants, and muscle relaxants. A review of pharmacology in the geriatric patient can be found in the article by [Welker KL, Mycyk MB: Pharmacology in the Geriatric Patient](#), in this issue.

Assessing level of consciousness (arousal)

A bedside examination should assess the patient's level of consciousness using an objective bedside tool. These tools can assist in diagnosing delirium, and abnormal levels of consciousness are associated with mortality.

Table 1		
Predisposing risk factors for delirium		
Demographics	Comorbid Disease	Drugs
<ul style="list-style-type: none"> • Advanced age • Male gender 	<ul style="list-style-type: none"> • Number of comorbidities • Severity of comorbidities • Visual impairment • Hearing impairment • Dementia • Depression • History of delirium • Cerebrovascular disease • Falls • Functional impairment • Terminal illness • Malnutrition 	<ul style="list-style-type: none"> • Polypharmacy • Baseline psychoactive medication use • Alcohol abuse • Drug abuse

Adapted from Inouye SK. Delirium in older persons. *N Engl J Med* 2006;354(11):1160.

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